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	474001	A. BUILDING _____ B. WING _____	C 03/21/2012

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A 000	INITIAL COMMENTS Based on 2 Conditions of Participation (Nursing and Pharmacy Services) not being met during a complaint survey completed on 1/26/12, the Centers for Medicare and Medicaid Services authorized a full hospital survey to review all of the Conditions of Participation, including the Acute Hospital and Psychiatric Hospital Regulations. The joint survey was completed on 3/21/12 and included a review of 5 regulatory complaints. The following deficiencies were cited.	A 000		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on staff interviews and record review the Conditon of Nursing Services was not met as evidenced by staff failure to provide patient care in accordance with the facility's policy and protocols and to conduct ongoing health status assessments when there is an identified change in patient condition. Refer to A-0395 and A-0405	A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interview and record review nursing staff failed to follow the facility's policies	A 395		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] J.D., MPH | President + CEO | 4/6/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

March 30, 2012

Mr. Robert Simpson, Administrator
Brattleboro Retreat
Anna Marsh Lane Po Box 803
Brattleboro, VT 05301

Provider ID:474001

RE: Full survey of Brattleboro Retreat completed on **March 21, 2012**

Dear Mr. Simpson:

To participate in the Medicare & Medicaid programs, Acute Care Hospitals must meet the requirements in the Code of Federal Regulations (CFR) 482 established by Centers for Medicare & Medicaid Services (CMS). Failure to comply with all Conditions of Participation may result in termination of your provider agreement.

Following a complaint investigation completed on **January 26, 2012**, a full survey of all the Hospital Conditions of Participation was completed on **March 21, 2012**. Based upon survey findings, Brattleboro Retreat was found to be out of compliance with the Conditions of Participation for 42 C.F.R. §482.23 - Nursing Services and 42 C.F.R. §482.25 - Pharmaceutical Services as well as several standard level requirements.

This letter serves to notify you of Brattleboro Retreat's failure to comply with the Conditions of Participation as stated above. The projected date on which your agreement will terminate is **June 19, 2012.** Under Federal disclosure rules, a copy of the findings of theis Medicare survey must be publicly disclosed upon request within 90 day so of the completion.

Please submit a plan of correction for all deficiencies by **April 9, 2012**. A revisit will occur.

If you have any questions concerning this letter, please contact me at (802) 871-3317.

Sincerely,

Frances L Keeler

Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
Director State Survey Agency

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A 395	Continued From page 1 and protocol for medication administration and safety searches, and failed to assure the ongoing evaluation and assessment of patient care needs and health status for 3 patients. (Patient's #1, #2 and #20). Findings include: 1. Per record review staff failed to follow the facility's policy titled Administration and Scheduled Time of Medication, last revised and approved in July of 2011, which stated: III. Verifications, Education and Discussion: "Before administering medication staff will: Verify that there is no contraindication for administering the medication." In addition the facility's protocol for responding to missing medication, titled Safety Searches - Unit Lock-down for Contraband, dated June 2006, which stated; "All medication passes are to be halted and no medication may be given until cleared with the Unit Manager or Supervisor", was not followed. Per record review Patient #1, who was admitted to the Tyler 2 Unit on 1/18/12 for treatment of suicidal ideation and alcohol detox., was able to obtain and ingest the Methadone (opiate) prescribed for Patient #2 during a medication (med) pass on the morning of 1/19/12. Per interview, at 3:20 PM on 1/24/12, Nurse #1 who was responsible for med pass for all patients on Tyler 2 on 1/19/12, stated that s/he was inside the med room that morning with the bottom half of the Dutch style door to the room closed. S/he stated s/he had prepared medications for several patients and placed the meds in individual plastic med cups, identified by patient name, on the top of the med cart which was located next to the door and within arm's reach of someone standing outside the door. Nurse #1 stated that Patient #1	A 395		

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A 395	Continued From page 2 presented at the med room door for his/her medication at approximately 9:00 or 9:30 AM that day. S/he stated that the patient, who was on an alcohol detox program had an assessment conducted by his/her primary nurse, in accordance with the Alcohol Detox protocol, that identified a score which required administration of 75 mg of Librium (benzodiazipine used to relieve anxiety and control agitation caused by alcohol withdrawal) . Nurse #1 stated that s/he administered the Librium and Patient #1 continued to stand leaning on the shelf of the half door repeatedly requesting Ritalin, for which there was no physician order, while other patients lined up in the hallway awaiting their turns for med administration. Nurse #1 stated that s/he had turned his/her head away from the patient for a short period just once during the exchange with Patient #1. Following the exchange, Patient #1 left the area of the med room and the nurse continued to administer meds to other patients. Nurse #1 stated it was within 15 minutes of the exchange with Patient #1 that Patient #2 presented to the med room door asking for their daily maintenance dose of 110 mg of Methadone and the nurse was not able to find the pre-poured medication. S/he stated s/he had previously prepared the (2) 40 mg wafers and (6) 5 mg tablets to total the 110 mg dose, placed them in a plastic med cup with another plastic med cup covering it and placed it on top of the med cart. Nurse #1 stated that s/he alerted other staff and the Pharmacy that the Methadone was missing. S/he stated that, with the assistance of a pharmacy technician, they searched, unsuccessfully, throughout the med room for the Methadone. The protocol for Safety Searches - Unit Lock down for Contraband was implemented	A 395		

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A 395	Continued From page 3 immediately following the identification of missing Methadone; patients were gathered in the community area as individual room searches were conducted and the process of obtaining urine for drug screening was initiated on all patients. Nurse #1 stated that, during this time, although s/he had not consulted Patient #2's attending physician, s/he did speak with a Pharmacist about providing the maintenance dose of Methadone to Patient #2 who had still not received the medication. Despite the fact that administration of Methadone to Patient #2 was contraindicated because staff had not been able to account for the missing Methadone, it was not in accordance with the protocol that stated to halt all medication administration, and, finally, without consulting with the attending physician or Nurse Manager, Nurse #1 confirmed that s/he administered 110 mg of Methadone to Patient #2 (at 9:30 AM according to the Medication Administration Record). In addition Nurse #1 stated that s/he continued to administer medication to the 3 or 4 patients that had still not received their scheduled medications. During interview, at 3:45 PM on 1/24/12, Nurse #2, the Charge Nurse on Tyler 2 on 1/19/12, confirmed that following the identification of the missing Methadone the Nurse Manager, Supervisor and Physicians on the unit were all notified; the patients were gathered in the community area and room searches were conducted on the individual patient rooms. Nurse #2 stated that during this period Patient #1 approached him/her and admitted that s/he had found a white pill (a 40 mg wafer of Methadone) on the floor of the bathroom that morning and had ingested it. A body search was then conducted on	A 395		

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A 395	Continued From page 4 Patient #1 and during the contraband search of Patient #1's room s/he revealed a 5 mg tablet of Methadone that had been taped to the underside of a drawer. Patient #1 was placed on 1:1 observation status and after beginning to exhibit symptoms of Methadone overdose, including slurred speech, decreased respirations, increasing lethargy and constricted pupils, s/he was transferred, at 11:55 AM, to the ER (Emergency Room) for treatment. Patient #1 returned to the facility approximately 3 and a half hours later at 3:30 PM, was transferred to the Tyler I Unit and subsequently returned to the ER at approximately 5:00 PM that evening as a result of continuing to exhibit symptoms associated with Methadone overdose. Per interview, at 12:53 PM on 1/25/12, the Tyler II Nurse Manager confirmed that Nurse #1 had continued to administer meds to patients after Methadone had gone missing and further stated that s/he had told Nurse #1 and all staff that medication administration had to be halted because they could not account for the missing Methadone. 2. Per record review staff failed to provide ongoing assessments of health status for Patient #1 who was readmitted to the facility on the afternoon of 1/20/12, following an acute care stay in the ICU (Intensive Care Unit) for monitoring and treatment of Methadone overdose. Per review of documentation completed at the hospital during Patient #1's acute care stay from 1/19/12 through 1/20/12, a nurse's note, dated 1/20/12 at 6:15 AM stated the patients's O2 (oxygen) saturation had dropped into the 80's when asleep requiring the use of oxygen to	A 395		

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A 395	Continued From page 5 increase the saturation to a more normal level of 94-97%. The note also revealed that the patient had stated, "I have sleep apnea". Although a history and physical had been conducted by medical staff upon the Patient's return to the facility on the evening of 1/20/12 , there was no evidence that facility staff were aware of the recent history of low O2 sats during sleep and the patient identified sleep apnea. The patient received 800 mg of Ibuprofen at 3:30 PM, (at which time his/her temperature was recorded as 100.1 degrees Fahrenheit), for complaints of a sore throat associated with a diagnosis of acute Uvulitis. Patient #1 was admitted to Tyler 1 at 6:40 PM and placed on observation status that included every 15 minute checks. The patient's temperature was taken on just two subsequent occasions and was recorded as 99.7 at 6:45 PM and 98.4 at 9:30 PM, respectively. Per review of the Nursing Observation Flow Sheet, dated 1/20/12, the patient was ambulating about the unit and talking with the nurse and other patients during the evening hours following admission, and was noted to be awake until approximately 12:30 AM. During the time period between 4:00 - 5:30 AM the patient was noted, every 15 minutes, to be yelling in sleep and snoring loudly. An Addendum for 1/21/12, documented by MHW (Mental Health Worker #2) on 1/24/12 at 2:20 AM, stated that, between 4:15 AM and 5:00 AM Patient #1 was doing " a lot of yelling in....sleep.. It sounded angry almost as if growling" and staff questioned if patient was having a nightmare. The record also stated that staff had attempted to awaken Patient #1 "numerous times as a means to get (patient) out of the dream or whatever was going on. This was done by calling (patient) name	A 395		

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A 395	Continued From page 6 repeatedly with 1 response of "huh". Despite the previous recent history of low O2 sats during sleep, the patient's statement that s/he had sleep apnea, as well as the diagnosis of acute Uvulitis and elevated temperature on admission, and the noted change in Patient #1's condition exhibited by symptoms of intermittent yelling during sleep for a prolonged period, with difficulty arousing the patient, there was no evidence that nursing staff had conducted any health status assessment of the patient after 9:30 PM. During a subsequent visual check at 5:43 AM the patient was found unresponsive and without respirations, a Code Blue was called, CPR (Cardiopulmonary Resuscitation) was initiated and Patient #1 was subsequently transferred to the ER where s/he expired. During separate interviews, conducted at 7:50 AM on 1/25/12 and 11:02 AM on 1/26/12, respectively, MHWs (Mental Health Workers) #1 and #2, both of whom had worked the Tyler I unit on the 11:00 PM - 7:00 AM shift on the night of 1/20/12 through 1/21/12 confirmed that Patient #1 had begun yelling in his/her sleep at approximately 4:00 AM and continued to do so until 5:35 AM. They stated that the night light was on in the patient's room providing enough light to determine that the patient's color remained good throughout the night. Patient #1 was described as yelling frequently and loud enough at times to awaken other patients. The MHWs stated that they had attempted to arouse the patient when s/he yelled and, although s/he would stop yelling the patient never awoke. MHW #2 stated that the patient "was obviously having a hard time." and s/he voiced concerns about Patient #1, to Nurse #3, the Charge Nurse on Tyler I during the 11:00	A 395		

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A 395	Continued From page 7 PM - 7:00 AM shift at the time. Nurse #3 told MHW #2 to just continue checking on the patient. At 5:35 AM Patient #1 was yelling again and was checked by both the MHWs. MHW #1 next conducted a visual check of Patient #1 approximately 8 minutes later at 5:43 AM and found the patient unresponsive. Nurse #3, stated during interview at 11:02 AM on 1/25/12, that, although s/he does not routinely perform visual checks of patients during the night, s/he had visually checked on Patient #1 at least 4 times during the shift because of the concerns by MHWs regarding the patient's prolonged intermittent yelling. Nurse #3 stated that, although the patient's color was good, and the patient was moving about in bed, s/he "was screaming and hollering at times", and even woke up other patients s/he "was so loud". S/he further stated that s/he did not attempt to awaken Patient #1. Nurse #3 stated that, although s/he had received report that Patient #1 had been readmitted to the unit following acute care treatment for Methadone overdose, s/he had not been aware of Patient #1's elevated temperature or diagnosis of Uvulitis, and confirmed that s/he had not conducted any assessment of the patient's health status. Nurse #3 stated that s/he was called to Patient #1's room at approximately 5:43 AM and found the patient unresponsive and without respirations or pulse. S/he stated that CPR was initiated and a Code Blue was called. Patient #1 was subsequently transferred to the ER by ambulance at approximately 6:20 AM. During interview, at 9:42 AM on the morning of 1/26/12, the Senior Vice President of Patient Care Services and CNO (Chief Nursing Officer) confirmed the lack of health status assessment	A 395		

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A 395	Continued From page 8 for Patient #1 and stated that s/he would have expected nursing staff to conduct an assessment of the patient related to the patient's change in condition exhibited by prolonged yelling out and lack of response to staff attempts to arouse him/her during the night of 1/21/12. 3. Per record review, staff failed to evaluate Patient #20's health status, including Fall Risk, after the patient sustained a fall on 9/30/11. The patient, who utilized a cane to assist with ambulation, had a Fall Risk Assessment completed on admission, on 9/27/11, and was identified as low fall risk. A Shift Progress/Reassessment Note, dated 9/30/11 at 2:15 PM, stated; "difficulty getting around at times (fell onto both knees). Pt fell in community this am and was escorted to.....had room changed to.....Pt in wheelchair". There was no evidence that assessment of the patient's health status, including a re-assessment of fall risk status, had been conducted by nursing staff. The patient subsequently sustained a second fall, 3 days later on 10/3/11, with injury that required transfer to an acute care hospital for evaluation and treatment. During interview, at 10:51 AM on 3/21/11, the RN who was in the position of unit Charge Nurse on 9/27/11 at the time of the fall, stated that the fall was not witnessed and s/he did not document any information in the patient's medical record. The RN also confirmed that evaluation of the patient's health status and re-assessment of fall risk status had not been conducted after the fall on 9/30/11. Refer also to A-0396	A 395	A 395 482.23(B) (3) RN SUPERVISION OF NURSING CARE PAGE 9 Interview on 3/21/12 The Quality department began monitoring of the fall risk assessment and reassessment and care planning process in October 2011 after a Root Cause Analysis was conducted concerning the fall of a 72 year old female noted in the CMS survey report. The quality audits revealed that the fall risk assessment tool was used on admission by the A and E RN staff and a treatment plan developed. The tool was not used consistently for re-assessment of falls during the course of treatment and care plans were not revised accordingly. A Performance Improvement team was chartered and consisted of representatives from inpatient unit RN's, Managers and was led by the PI/Risk Manager. Using the Juran process, the team identified system issues and interventions and reviewed evidence based and best practice tools and literature. The team chose the Decision Health Best Practice tool and customized it for the particular needs of the Brattleboro Retreat. This new fall risk assessment/reassessment tool and care plan created by the Falls Risk PI Team will allow for the ease of documenting assessments, re-assessments, and nursing care planning. The new tool and care plan was reviewed and approved by Nursing Council and Joint Practice for a pilot on the Tyler 1 Co-Occurring Disorders unit and the pilot began at the end of November 2011. The tool pilot allowed for review by nursing staff and refinement based on nursing staff use and feedback. As the new assessment tool has space for reassessments that can be easily compared to the previous fall risk score, and has an attached nursing care plan for fall risk it has improved the ability of Nursing Staff to comply with the policy and procedure.	
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.	A 396		

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A 396	Continued From page 9 This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that nursing staff developed and kept current a nursing care plan to address each patient's needs for 6 of 30 patients in the applicable sample. (Patients # 26, 15, 16, 19, 20 & 5) Findings include: 1. Per record review on 3/20/12, Patient #15 had specific medical needs related to dental and foot pain. During an interview with the Clinical Manager and confirmed on 3/20/12 at 11:50 AM, staff failed to revise the nursing care plan for Patient #15 to include specific interventions, goals, and measurable objectives for foot and dental pain to assure that nursing addressed these needs. 2. Per record review on 3/19/12, Patient #16 had a specific medical need related to a gastrostomy tube (a surgical opening and tube to permit intake of nutritional fluids) and the 3/17/12 Admission Skin Assessment Form documented that Patient #16 had a gastrostomy tube. During an interview with the Clinical Manager and confirmed on 3/19/12 at 3:20 PM, staff failed to develop a nursing care plan for Patient # 16 to include specific interventions, and measurable goals/objectives related to the gastrostomy tube, to assure that nursing addressed this need. 3. Per record review on 3/20/12, the Initial Care Plan for Patient #19, who was admitted to the hospital after voicing suicidal ideation, failed to address this assessed need. Per the Comprehensive Intake Examination signed 3/11/12 at 0530, the patient "Repeatedly	A 396	Beginning on April 12th, 2012, just in time education and the new fall risk assessment/reassessment tool and care plan will be implemented on all inpatient units. Both of these documents will be kept with the Nursing Kardex and the patient's fall risk and care plan interventions will passed along in shift to shift report. The Quality department will review 20 patient records a week for compliance with the new process until 100% compliance is achieved; thereafter the Quality department will continue to conduct monthly audits of patient care records for compliance. Weekly feedback will be sent to Inpatient Clinical managers for review with their respective staff. Any patterns ascertained by the quality department as to trends in individual staff performance will also be communicated weekly to Inpatient Managers for use in the disciplinary action process. Additionally, a new open chart audit tool has been developed and Managers are required to complete weekly and submit to both the Interim Director of Nursing and the Senior Director of Standards and Quality Management. This will allow for a weekly review of open records and the ability of Managers to work with staff to correct identified issues via a late entry, prior to the closure of the medical record. This process was initiated on 3/12/12.	

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A 396	Continued From page 10 verbalized suicidal ideation". Although the RN Safety Assessment dated 3/10/12 at 9 PM included a safety plan stating "Pt. in LSA (low stimulation area) x 24 hr. with 1:1 staffing until TX (treatment) team re-assess.", a later RN Safety Assessment dated 3/11/12 at 0530, included no suicidal ideation care plan. The lack of a care plan to address this need was confirmed during interview with the Unit RN Manager at 11:30 AM on 3/20/12. 4. Per record review on 3/19/12, nursing staff failed to initiate a care plan to address interventions for Patient #5, who was admitted to the hospital for treatment of alcohol addiction compounded by a diagnosis of an "Eating Disorder". Since admission on 3/17/12, the patient had demonstrated behaviors associated with the eating disorder including purging through vomiting and limiting consumption of food. Per interview on the afternoon of 3/19/12, the Unit Manager confirmed that Patient #5 was demonstrating behaviors related to the eating disorder and a nursing care plan had not been initiated to direct staff with the management and approaches necessary to address this need. 5. Per record review, staff failed to revise Patient #20's care plan to reflect a fall and interventions implemented to reduce the risk of further falls. The patient, who utilized a cane to assist with ambulation, had a Fall Risk Assessment completed upon admission on 9/27/11. The patient was identified as low fall risk, and had a care plan initiated that included "Level 1: Universal (low) Fall Risk Prevention Strategies (instituted for everyone)". A Shift Progress/Reassessment Note, dated 9/30/11 at	A 396	A 396 482.23 (b) (4) NURSING CARE PLAN The CEO, VP of Clinical Operations, Interim Director of Nursing, Senior Director of Standards and Quality Management, Senior Director of Admissions and Ambulatory Services Senior Medical Director and Associate Medical Director met with all Inpatient Managers on March 21st immediately following the CMS Exit Interview. The CEO instructed the Senior Medical Director and Interim Director of Nursing to immediately charter a rapid performance improvement team for treatment planning and nursing care plans. As there was a PI team that had been meeting to address treatment planning, the work to date has been incorporated into new rapid redesign team chaired by Dr. Engstrom, Senior Medical Director and Deb Lucey RN, MS, Interim DON. The team began meeting on Tuesday March 27th and meets weekly. The team has gathered samples of what other psychiatric hospitals and units are using as well as conducting a literature review. Interventions identified to date are as follows: Initiated March 31st, 2012 1. Deb Lucey RN, MS, Interim DON, has met with all Inpatient managers and has instructed them to assign the completion of the nursing care plans to the unit admissions nurse for all initial problems. 2. For on-going care plan problems, Deb Lucey RN, MS, Interim DON, has assigned each manager of an Inpatient Unit to attend treatment team and ensure that any new problem that arises has an appropriate care plan. 3. The quality department continues to conduct 20 chart audits weekly to monitor for staff compliance. Any patterns ascertained by the quality department as to trends in individual staff performance will also be communicated weekly to Inpatient Managers for use in the disciplinary action process. 4. The Quality department will review 20 patient records a week for compliance with the new process until 100% compliance is achieved; thereafter the Quality department will continue to conduct monthly audits of patient care records for compliance.	

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A 396	Continued From page 11 2:15 PM, stated; "difficulty getting around at times (fell onto both knees). Pt fell in community this am and was escorted to.....had room changed to.....Pt in wheelchair". During interview, at 10:51 AM on 3/21/11, the RN who was in the position of unit Charge Nurse on 9/27/11 at the time of the fall, stated that although s/he had moved the patient to a room closer to the nursing station to monitor more closely and had provided a wheel chair for the patient to use for long distance locomotion, the care plan had not been updated to reflect these changes. The patient subsequently sustained a second fall, 3 days later on 10/3/11, with injury that required transfer to an acute care hospital for evaluation and treatment. Refer also to A-0395 6. a. Per record review on 3/20/12, nursing staff failed to develop a care plan related to Patient # 26 's refusal to allow hospital staff to administer her medications, which included psycho-active drugs. The patient was admitted to the hospital on 8/29/11 with a diagnosis of schizo-affective disorder and delusions. Beginning on 8/29/11 and for the first 72 days of his/her admission, the patient refused to allow staff to administer medications. On 11/11/11 a court order was obtained for the hospital staff to administer involuntary meds, and staff was then able to administer medications to the patient. On 3/20/12 at 4 P.M. the acting Director of Nursing (DNS) confirmed that the facility failed to develop a careplan related to the patient's refusal to take his/her medications and the behaviors s/he manifested as a consequence of not taking them. b. Per record review on 3/20/12, nursing staff	A 396	To be initiated April 10th, 2012 1. The Senior Medical Director and Associate Medical will meet with all medical staff and request that they provide assistance to the nursing staff in treatment team and ensure that all nursing care plans are completed. 2. The new open chart audit tool will be revised to incorporate the change in policy and practice for nursing assessments and model of care delivery. Inpatient Managers will still be required to complete weekly and submit to both the Interim Director of Nursing and the Senior Director of Standards and Quality Management. This will allow for a weekly review of open records and the ability of Managers to work with staff to correct identified issues. April 18 per T.C. Shaw Chapman RN Mary Bolton RN 4/12/12 To be initiated ~~May 14th~~, 2012 1. The Nursing Assessment will be revised and an A and E Triage RN assessment will be developed and will be streamlined and incorporated with the CIE completed by an LIP on admission. 2. All treatment plans will be triggered by the Comprehensive Intake Evaluation and physical completed by an LIP and the Nursing Assessment on admission of the patient. 3. The multidisciplinary team will then meet within 72 hours to incorporate social services, chemical dependancy, psychiatric and therapeutic services assessments and determine the master treatment plan. May 14, 2012 per T.C. Shaw Chapman RN Mary Bolton RN 4/12/12 To be initiated by ~~May 31st~~: 1. The Nursing Assessment will be conducted on the unit as part of the institution of the new care delivery model, Team/Modified Primary model, described in the previous CMS action plan related to these events. 2. The Quality department will review 20 patient records a week for compliance with the new nursing assessment and care planning process until 100% compliance is achieved; thereafter the Quality department will continue to conduct monthly audits of patient care records for compliance.	

POC 1396 accepted 4/19/12 Mary Bolton RN

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A 396	Continued From page 12 failed to develop a care plan for hygiene issues manifested by Patient # 26's refusal to bathe, wash his/her hair, and refusal to allow staff to assist with incontinence care. The patient was unable to complete her own activities of daily living (ADL's) and refused to allow staff to assist him/her. This was confirmed on 3/20/12 at 3:50 P.M. by the acting DNS. c. Per record review on 3/20/12, nursing staff failed to develop a care plan for weight loss for Patient # 26 although her history included a significant weight loss the months before entering the hospital and her poor nutritional intake while a hospital patient. This was confirmed by the acting DNS on 3/20/12 at 4 P.M. d. Per record review on 3/20/12, for Patient # 26, although a diabetic/hypo/hyperglycemia care plan had been developed upon admission, nursing staff failed to revise the careplan when the patient refused to allow staff to check her finger stick blood sugar/accuchecks for glucose monitoring during her entire hospital stay (between 8/29/11 and 12/23/11). This was confirmed on 3/20/12 at 4 P.M. by the acting DNS.	A 396		
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by:	A 405		

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A 405	Continued From page 13 Based on staff interview and record review nursing staff failed to administer medications in accordance with established policies and protocols and resulting in the potential for and actual negative outcome for 2 patients. (Patients #1 and #2). Findings include: Per record review staff failed to follow the facility's policies which included: the policy for Medication Procurement, Distribution, Storage and Disposition, last revised in July 2011 and which stated: Medication Storage and Disposition; When a medication is delivered to a unit it shall be locked in the designated location in the medication room unless it is to be administered immediately.....All Controlled Substances stored on the unit shall be secured and locked inside the medication cart drawer or a cabinet; the policy titled Administration and Scheduled Time of Medication, last revised and approved in July of 2011, which stated: III. Verifications, Education and Discussion: "Before administering medication staff will: Verify that there is no contraindication for administering the medication"; and the protocol for responding to missing medication, titled Safety Searches - Unit Lock-down for Contraband, dated June 2006, which stated; "All medication passes are to be halted and no medication may be given until cleared with the Unit Manager or Supervisor". Patient #1, who was admitted to the Tyler 2 Unit on 1/18/12 for treatment of suicidal ideation and alcohol detox., was able to obtain and ingest the Methadone (opiate) prescribed for Patient #2 during a medication (med) pass on the morning of 1/19/12. Per interview, at 3:20 PM on 1/24/12, Nurse #1, who was responsible for med pass for	A 405		

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A 405	Continued From page 14 all patients on Tyler 2 on 1/19/12, stated that s/he was inside the med room that morning with the bottom half of the Dutch style door to the room closed. Although the facility's policy for storage of medication specifies that medication delivered to a unit shall be locked in the designated location in the med room unless it is to be administered immediately, and all Controlled Substances, like Methadone, stored on the unit shall be secured and locked inside the medication cart drawer or a cabinet, Nurse #1 stated that s/he had prepared medications for several patients, placed the meds in individual plastic med cups, identified by patient name, and lined the cups up on the top of the med cart which was located next to the door and reachable by someone standing outside the door. Nurse #1 stated that Patient #1 presented at the med room door for his/her medication at approximately 9:00 or 9:30 AM that day. S/he stated that the patient, who was on an alcohol detox program, received 75 mg of Librium (benzodiazipine used to relieve anxiety and control agitation caused by alcohol withdrawal) at that time but continued to stand at the door, leaning on the shelf of the half door and repeatedly asking for Ritalin, for which there was no physician order, while other patients lined up in the hallway awaiting their turns for med administration. Nurse #1 stated that s/he had turned his/her head away from the Patient #1 for a short period just once during the exchange. Patient #1 left the area of the med room and the nurse continued to administer meds to other patients. Nurse #1 stated it was within 15 minutes of the exchange with Patient #1 that Patient #2 presented to the med room door asking for their daily maintenance dose of 110 mg of Methadone and the nurse was not able to find the pre-poured	A 405		

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A 405	Continued From page 15	A 405		

medication. S/he stated s/he had previously prepared the (2) 40 mg wafers and (6) 5 mg tablets totaling the 110 mg dose, placed them in a plastic med cup with another plastic med cup covering it and placed it on top of the med cart prior to the exchange with Patient #1. Nurse #1 stated that s/he alerted other staff and the Pharmacy that the Methadone was missing. S/he stated that, with the assistance of a pharmacy technician, they searched, unsuccessfully, throughout the med room for the Methadone. The protocol for Safety Searches - Unit Lock down for Contraband was implemented immediately following the identification of missing Methadone; and patients were gathered in the community area.. Nurse #1 stated that, during this time, although s/he had not consulted Patient #2's attending physician, s/he did speak with Pharmacist #1 about providing the maintenance dose of Methadone to Patient #2 who had still not received the medication and the Pharmacist told Nurse #1 that Patient #2 needed the medication. Despite the fact that administration of Methadone to Patient #2 was contraindicated because staff had not been able to account for the missing Methadone, and it was a violation of the protocol that stated to halt all medication administration, and, finally, without consulting the attending physician, Nurse #1 confirmed that s/he administered 110 mg of Methadone to Patient #2 (at 9:30 AM according to the Medication Administration Record). In addition Nurse #1 stated that s/he continued to administer medication to the 3 or 4 patients that had still not received their scheduled medications.

Nurse #2 stated during interview at 3:45 PM on 1/24/12, that while all patients were gathered in

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A 405	Continued From page 16 the community area of the unit, Patient #1 approached him/her and admitted that s/he had found a white pill (a 40 mg wafer of Methadone) on the floor of the bathroom that morning and had ingested it. A body search was then conducted on Patient #1 and during the contraband search of Patient #1's room s/he revealed a 5 mg tablet of Methadone that had been taped to the underside of a drawer. Patient #1 was placed on 1:1 observation status and after beginning to exhibit symptoms of Methadone overdose, including slurred speech, decreased respirations, increasing lethargy and constricted pupils, s/he was transferred, at 11:55 AM, to the ER (Emergency Room) for treatment. Patient #1 returned to the facility approximately 3 and a half hours later at 3:30 PM, was transferred to the Tyler I Unit and subsequently returned to the ER at approximately 5:00 PM that evening as a result of continuing to exhibit symptoms associated with Methadone overdose. Per interview, at 12:53 PM on 1/25/12, the Tyler II Nurse Manager confirmed that Nurse #1 had continued to administer meds to patients after Methadone had gone missing and further stated that s/he had told Nurse #1 and all staff that medication administration had to be halted because they could not account for the missing Methadone.	A 405		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and	A 490		

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A 490	Continued From page 17 procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on staff interviews and record review the Condition of Pharmacy Services is not met as evidenced by the failure to ensure safe and secure storage of all drugs in accordance with established policies and protocols, to prevent access by patients, and resulting in a negative patient outcome. In addition there was a failure to assure that pharmacy staff provided information to nursing staff in a manner that would promote safe medication use in accordance with established policies and protocols.	A 490		
A 502	Refer to tag A-0502 482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on staff interview and record review the Pharmacy Department failed to ensure that all Controlled drugs were securely stored in a manner that prevented unauthorized access by patients, and failed to assure that medications were administered in a manner consistent with facility Policies and Procedures. Findings include:	A 502		

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A 502	Continued From page 18 Per record review staff failed to follow the facility's policies which included: the policy for Medication Procurement, Distribution, Storage and Disposition, last revised in July 2011 and which stated: Medication Storage and Disposition; When a medication is delivered to a unit it shall be locked in the designated location in the medication room unless it is to be administered immediately.....All Controlled Substances stored on the unit shall be secured and locked inside the medication cart drawer or a cabinet; the policy titled Administration and Scheduled Time of Medication, last revised and approved in July of 2011, which stated: III. Verifications, Education and Discussion: "Before administering medication staff will: Verify that there is no contraindication for administering the medication"; and the protocol for responding to missing medication, titled Safety Searches - Unit Lock-down for Contraband, dated June 2006, which stated; "All medication passes are to be halted and no medication may be given until cleared with the Unit Manager or Supervisor". Patient #1, who was admitted to the Tyler 2 Unit on 1/18/12 for treatment of suicidal ideation and alcohol detox., was able to obtain and ingest the Methadone (opiate) prescribed for Patient #2 during a medication (med) pass on the morning of 1/19/12. Per interview, at 3:20 PM on 1/24/12, Nurse #1, who was responsible for med pass for all patients on Tyler 2 on 1/19/12, stated that s/he was inside the med room that morning with the bottom half of the Dutch style door to the room closed. Although the facility's policy for storage of medication specifies that medication delivered to a unit shall be locked in the designated location in the med room unless it is to be administered	A 502		

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A 502	Continued From page 19	A 502		

immediately Nurse #1 stated that s/he had prepared medications for several patients, placed the meds in individual plastic med cups, identified by patient name, and lined the cups up on the top of the med cart which was located next to the door and reachable by someone standing outside the door. Nurse #1 stated that Patient #1 presented at the med room door for his/her medication at approximately 9:00 or 9:30 AM that day. S/he stated that the patient, who was on an alcohol detox program, received 75 mg of Librium (benzodiazipine used to relieve anxiety and control agitation caused by alcohol withdrawal) at that time but continued to stand at the door, leaning on the shelf of the half door and repeatedly asking for Ritalin, for which there was no physician order, while other patients lined up in the hallway awaiting their turns for med administration. Nurse #1 stated that s/he had turned his/her head away from the Patient #1 for a short period just once during the exchange. Patient #1 left the area of the med room and the nurse continued to administer meds to other patients. Nurse #1 stated it was within 15 minutes of the exchange with Patient #1 that Patient #2 presented to the med room door asking for their daily maintenance dose of 110 mg of Methadone and the nurse was not able to find the pre-poured medication. S/he stated s/he had previously prepared the (2) 40 mg wafers and (6) 5 mg tablets totaling the 110 mg dose, placed them in a plastic med cup with another plastic med cup covering it and placed it on top of the med cart prior to the exchange with Patient #1. Nurse #1 stated that s/he alerted other staff and the Pharmacy that the Methadone was missing. S/he stated that, with the assistance of a pharmacy technician, they searched, unsuccessfully,

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A 502	Continued From page 20 throughout the med room for the Methadone. The protocol for Safety Searches - Unit Lock down for Contraband was implemented immediately following the identification of missing Methadone; and patients were gathered in the community area.. Nurse #1 stated that, during this time, although s/he had not consulted Patient #2's attending physician, s/he did speak with Pharmacist #1 about providing the maintenance dose of Methadone to Patient #2 who had still not received the medication and the Pharmacist told Nurse #1 that Patient #2 needed the medication. Despite the fact that administration of Methadone to Patient #2 was contraindicated because staff had not been able to account for the missing Methadone, and it was a violation of the protocol that stated to halt all medication administration, and, finally, without consulting the attending physician, Nurse #1 confirmed that s/he administered 110 mg of Methadone to Patient #2 (at 9:30 AM according to the Medication Administration Record). In addition Nurse #1 stated that s/he continued to administer medication to the 3 or 4 patients that had still not received their scheduled medications. Nurse #2 stated, during interview at 3:45 PM on 1/24/12, that while all patients were gathered in the community area of the unit, Patient #1 approached him/her and admitted that s/he had found a white pill (a 40 mg wafer of Methadone) on the floor of the bathroom that morning and had ingested it. A body search was then conducted on Patient #1 and during the contraband search of Patient #1's room s/he revealed a 5 mg tablet of Methadone that had been taped to the underside of a drawer. Patient #1 was placed on 1:1 observation status and after beginning to exhibit	A 502		

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A 502	Continued From page 21 symptoms of Methadone overdose, including slurred speech, decreased respirations, increasing lethargy and constricted pupils, s/he was transferred, at 11:55 AM, to the ER (Emergency Room) for treatment. Patient #1 returned to the facility approximately 3 and a half hours later at 3:30 PM, was transferred to the Tyler I Unit and subsequently returned to the ER at approximately 5:00 PM that evening as a result of continuing to exhibit symptoms associated with Methadone overdose. During interview, at 10:14 AM on 1/25/12, Pharmacist #1 confirmed that Nurse #1 had contacted him/her on the morning of 1/19/12 to report that Methadone was missing. The Pharmacist stated that during the conversation the question came up about giving Patient #2 their prescribed Methadone. S/he stated that Nurse #1 had expressed that s/he was sure Patient #2 had not taken the Methadone and the Pharmacist told Nurse #1 that s/he would give the Methadone if positive Patient #2 hadn't had it. The Director of Pharmacy Services agreed, during interview at 9:50 AM on 1/25/12, that there was a potential for Methadone overdose to occur if a patient receiving a daily maintenance dose of 110 mg were given more than the maintenance dose. During a subsequent interview, at 9:55 AM on 1/26/12, the Director of Pharmacy Services agreed that administration of medication should be halted, in accordance with the facility's established protocol for Safety Searches - Unit Lock-down for Contraband during any event when staff are not able to account for missing patient medications. S/he further agreed that response by pharmacy staff to questions posed regarding	A 502		

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	474001	A. BUILDING _____ B. WING _____	C 03/21/2012

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A 502	Continued From page 22 medication administration during an event requiring a unit lock-down should reflect the directives in the protocol.	A 502		
A 620	482.28(a)(1) DIRECTOR OF DIETARY SERVICES The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This STANDARD is not met as evidenced by: Based on observations, staff interviews and log and policy/procedure reviews, the Director of Food Services (DFS) failed to assure that the hospital kitchen and food storage areas were maintained in a sanitary manner, in accordance with accepted safe food handling practices. Findings include: During the initial tour of the facility kitchen on 3/19/12 at 1:45 P.M., accompanied by the DFS, the following observations were made: 1. In the kitchen 3 bay pot sink, the sanitizer level was measured at less than the recommended level of 150 parts per million (PPM) for proper sanitization of dishware. The sink was in use at the time of the observation and levels were tested by both kitchen staff and the FSD 2. In the dry storage room, a cardboard box labeled "pinto beans" was observed uncovered, open to the air. Facility policy states that all bulk	A 620	PLAN OF CORRECTION A 620 482.28(a)(1) Director of Dietary Services Rick Krolick, Food Services Director ensured that all cited areas were immediately remedied on 3/21/12 and has begun daily rounding to assess for compliance with department policies and procedures for cleaning and ensuring safe food preparation, storage and handling practices. Rick Krolick, Food Services Director will formalize this process by developing a monitoring tool that focuses in on each area of non-compliance noted on the 3/21/12 survey. This tool will be implemented by 4/9/12. Rick or designated manager will then use the monitoring tool to conduct daily rounds to verify that each area of non-compliance has been completed to industry standards and Sodexo policies. Rick Krolick will submit the monitoring tools and compliance rate to the CMS and TJC continuous readiness meetings. Mary Ann Holt RN, Manager of infection Control has increased Infection Control Tracers from monthly to a weekly basis until the issues are resolved. She will submit IC tracers after completion to the Quality department for monitoring prior to the monthly CMS and TJC continuous readiness meeting noted above.	

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A 620	Continued From page 23 dry goods are to be in a metal or plastic lidded container. 3. A window screen, glass and sill directly above a food preparation table was soiled with dead insects, dust and debris. The window was open and the wind was blowing into the kitchen at the time of the observation. 4. A table-mounted manual can opener, including the base and the metal puncture blade, was heavily soiled with a dark colored viscous substance. 5. A spider web, approximately 1 foot in length and visible dust debris were observed directly over the door between the serving line and the main kitchen area. 6. Two metal racks where pots and pans were stored were visibly soiled with dust. All of the above observations were confirmed by the FSD at the time of the observations. Per review of freezer logs on 3/20/12 at 1:30 P.M., the potato freezer recorded temperatures were in excess of zero degrees Fahrenheit (F). Facility policy states that freezer temperature must be 0 degrees or below. Staff recorded temperatures twice daily, and between 12/31/11 - 1/20/12, temperatures exceeded 0 degrees on 36 occasions. During interview, the FSD confirmed these observations and stated that staff were expected to notify management of temperatures that were outside normal limits and in this case, had failed to do so. Per observations on 3/21/12 between 10:30 and 10:50 A.M., patient refrigerators on all units exceeded recommended temperatures. Per facility policy, perishable foods are to be kept at	A 620	Temperature Logs: Rick Krolick, Food Services Director has completed the following action items: All unit or program patient food refrigerator temperature logs were changed to state maximum of 40 degrees or below for the refrigerator and 0 degrees or below for the freezers, as acceptable for proper and safe food storage. All ambulatory, inpatient and residential areas will use the same temperature tracking logs. The log is completed daily and will denote the procedure to take if the refrigerator temperature is out of range. Rick has assigned housekeeping staff to check and log the temperature of all refrigerators containing patient food in the kitchen and inpatient units. The residential and ambulatory service programs will continue to have their respective staff checking and logging temperatures of the patient food refrigerators. Rick Krolick will monitor the logs for inpatient units to ensure daily temperatures have been taken and all appropriate action has been taken when temperatures are out of range and disciplinary action will be done for staff responsible for any incomplete logs. The residential and ambulatory services managers will monitor the logs for to ensure daily temperatures have been taken and all appropriate action has been taken when temperatures are out of range and disciplinary action will be done for staff responsible for any incomplete logs. Infection Control tracers will be done weekly for 1 month and then periodically thereafter as a double check system to monitor for compliance.	

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A 620	Continued From page 24 no more than 40 degrees F. Recorded temperatures for March 2012 exceeded 40 F 6 times on Osgood 1; 22 times on Tyler 1; 1 time on Tyler 2; 6 times on Tyler 3 and 4 times on Tyler 4. During an interview on 3/21/12 at 10:55 A.M., the FSD stated that housekeeping was responsible for taking temperatures for the unit refrigerators. Unit staff, with the exception of Tyler 3, stated that night shift nursing staff was responsible for the temperature recording. Additionally, the form used to record the temperatures indicated that temperatures were not to exceed 46 degrees F which is contrary to both facility policy and accepted safe food practice.	A 620	Rick Krolick will submit a monthly report to the CMS and TJC continuous readiness meetings stating the percent of compliance noted with his monitoring of the logs. Mary Ann Holt will submit IC tracers after completion to the Quality department for monitoring prior to the monthly meeting noted above. POC A620 accepted 4/19/12 Mary Holt, RN	